Blue Shield of California 1999
Access+ HMO[sm]

A Health Maintenance Organization

For changes in benefits see page 26.

Serving: Most of California

Enrollment Code:

SJ1 Self Only

SJ2 Self and Family

Enrollment in this Plan is limited; see page 11 for requirements.

Notice: Members currently enrolled in CareAmerica (enrollment code BJ) will automatically be transferred to Blue Shield of California Access+ HMO (enrollment code SJ) unless the member makes a positive election to change to another health benefits plan during Open Season.

Visit the OPM website at http://www.opm.gov/insure

and

this Plan's website at http://www.blueshieldca.com

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

RI 73-574

Blue Shield of California Access+ HMO

Blue Shield of California, 50 Beale Street, San Francisco, CA 94105-1808 has entered into a contract (CS2639) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called the Blue Shield of California Access+ HMO, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 26 of this brochure.

Table of Contents

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800/334-5847 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.

If you are New member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except: in the case of emergency as described on pages 18-19, or when you self-refer to a participating specialist under the Plan's Access+ HMO option as described on page 9.** If you are confined in a hospital on the effective date and you are not transferring from another FEHBP Plan, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See *"If you are hospitalized"* on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are Hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your Responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who eligible "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision**.**

Things to Keep in Mind

The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" on page 3. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).

Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.

The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.

An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.

You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.

You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.

An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.

Report additions and deletions, including divorces, of covered family members to the Plan promptly.

Things to Keep in Mind *Continued*

- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan if one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will have to pay for hospital coverage in certain cases in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from the Medicare Hotline at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 23 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after Enrollment Ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member also may be eligible for one of the following:

Former spouse Coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about coverage.

Temporary Continuation of Coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former eligible family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or

Temporary Continuation of Coverage (TCC) *Continued*

the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification And election Requirements

Separating employees -- Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children -- You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former Spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to Individual Coverage

When none of the above choices are available -- or chosen -- when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available **only** from Plan providers except during a medical emergency. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you Have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 800/334-5847 or you may write to Blue Shield of California Member Services Department, P.O. Box 272550, Chico, CA 95927. You may also contact the Carrier by fax at 916/351-7790.

Information that must be made available to you includes:

- Disenrollment rate for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met.
- Accreditations by recognized accrediting agencies and dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care To Plan members?

The Blue Shield of California Access+ HMO is an Individual Practice Association (IPA) model HMO with an extensive network of providers conveniently located in the communities where you live and work. The Blue Shield of California Access+ HMO offers a Health Plan with a choice of 254 HMO hospitals, 160 other acute care hospitals, 8,700 primary care doctors, 15,500 specialists, and other health care professionals. Each family member has the freedom to choose a different doctor. You or your dependent(s) may change primary care doctors by calling the Plan at 1-800/334-5847 or by submitting a Member Change Request Form to the Member Services Department. The change will be effective on the first day of the month following notice of approval by Blue Shield. Once your primary care doctor change is effective, all care must be provided or arranged by the new primary care doctor, except for OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same Medical Group or Physician Group as the primary care doctor and Access+ specialist visits.

Changing your primary care doctor during a course of treatment, during hospitalization or while pregnant may interrupt the quality and continuity of your care. For this reason, the effective date of your new primary care doctor, when requested in the three situations listed above, will be the first of the month following discharge from the hospital, delivery or the date it is medically appropriate to transfer your care to your new primary care doctor, as determined by the Plan. Exceptions must be approved by the regional Blue Shield Medical Director. For information about approval for an exception to the above provisions, please contact Member Services.

You will have the opportunity through our Personal Health Management Program[sm] to be an active participant in your own health care with the Blue Shield of California Access+ HMO by calling 1-880-244-4755. We'll help you make a personal commitment to maintain, and, where possible, improve your health status. We believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

Who provides care To Plan members?
Continued

Your Plan coverage includes worldwide emergency care. Members may also receive care for urgent services when traveling out-of-state through HMO-Blue-USA. Members must call 1-800/4-HMO-USA to obtain information about the nearest participating provider. To arrange for urgent care while traveling out of their service area within California, members should call their primary care physician or 1-800/334-5847.

As a partner in your health care with Blue Shield, you'll receive the benefit of Blue Shield's 59-year commitment to service.

Role of a primary Care doctor

The most important decision that you will make is your selection of a primary care doctor. It is through this doctor that most all other health services are obtained. Your primary care doctor is usually responsible for obtaining authorizations from the Plan before referring you to a specialist. You can self-refer to a participating physician in the same Medical or Physician Group as your primary care doctor under our Access+ HMO option and pay a $30 office copayment for this added freedom of choice (with the exception of mental health care, infertility, urgent care and allergy services). Services of other providers are covered only when there has been a referral by your primary care doctor, with the exception of the Access+ HMO option and OB/GYN services. Access+ HMO and OB/GYN visits must be to a physician in the same Medical or Physician Group as your primary care doctor to assure quality of care. Your primary care doctor will also make arrangements for hospitalizations.

Choosing your Doctor

The Plan's provider directory lists primary care doctors (family and general practitioners, pediatricians, and internists), with their locations and phone numbers, and whether or not the doctor is accepting new patients. Directories are updated on a regular basis (but are subject to change without notice) and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800/334-5847; you can find out if a doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: **When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

Should you decide to enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) you select for you and each member of your family.

If your primary care doctor discontinues participation in the Plan, Blue Shield will notify you in writing and designate a new primary care doctor for you in case you need immediate medical care. You will also be given the opportunity to select a new primary care doctor of your own choice within 15 days of this notification. Your selection must be approved by the Plan prior to receiving any services under the Plan.

Referrals for Specialty care

You must receive referrals from your primary care doctors before seeing any other doctor or obtaining special medical services. The exceptions to this are for true medical emergencies, when another physician is on call for your doctor, when you use an Access+ HMO participating specialist (not applicable to mental health care, infertility, urgent care and allergy services) and OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same Medical Group or Physician Group as the primary care doctor. In all other instances, referral to a specialist is done at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

The following procedures apply to all members except those using the Access+ HMO self-referral option. When you receive a referral from your primary care doctor, you must return to the primary care doctor after consultation. All follow-up care must be provided or authorized by the primary
Care doctor. On referrals, the primary care doctor will give specific instructions to the consultant

Facts about this Plan *continued*

Referrals for Specialty care *Continued*

as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for an authorization for the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and this health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

For new members

The following procedures apply to all members except those using the Access+ HMO self-referral option. If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred to your next appointment.

If you are selecting a new primary care doctor, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly, or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket Maximum

Copayments and coinsurance are required for a few benefits. However, copayments and coinsurance will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $1,000 per Self Only enrollment or $2,000 per Self and Family enrollment. This copayment/coinsurance maximum does not include payments for prescription drugs, outpatient mental health and substance abuse services, infertility services or the Access+ HMO $30 visit copayment for self-referral specialty visits.

You should maintain accurate records of the copayments/coinsurance made, as it is your responsibility to determine when the copayment and coinsurance maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductibles and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Experimental/ Investigational Determinations

Access+ HMO covers drugs, devices that are medically indicated and biological products no longer considered to be investigational by the Food and Drug Administration. Coverage for other procedures are reviewed by and decided by the Blue Shield of California Medical Policy Committee. The primary criteria are that the proposed new procedures are safe and effective.

Submit claims Promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly to Blue Shield of California Access+ HMO, P.O. Box 272550, Chico, CA 95927. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other Considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's Service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You may enroll in this Plan if you live or work in these California counties:

County Name	Excluded ZIP Codes
Alameda	
Contra Costa	
El Dorado	95613, 95619, 95623, 95633, 95636, 95643, 95651, 95656, 95667, 95672, 95682, 95684, 95709, 95720, 95721, 95726, 95735, and 96150 to 96158
Fresno	
Kern	93501, 93502, 93504, 93505, 93516, 93519, 93527, 93528, 93554 to 93556, 93560 and 93596
Kings	
Los Angeles	90704
Madera	
Marin	
Merced	
Napa	
Nevada	95724, 95728, 96111 and 96160 to 96162
Orange	
Placer	95701, 95714, 95715, 95717, 96140 to 96143, 96145, 96146 and 96148
Riverside	
Sacramento	
San Bernardino	
San Diego	92242, 92280 and 92319
	91905, 91906, 91934, 91948, 91963, 91980, 91987, 91990 to 91995,
San Francisco	92004 and 92086
San Joaquin	
San Luis Obispo	
San Mateo	
Santa Barbara	
Santa Clara	
Santa Cruz	
Shasta	
Solano	
Sonoma	
Stanislaus	
Tulare	
Ventura	
Yolo	

Benefits for care outside the service area are limited to emergency services as described on pages 18-19 and urgent care services provided through HMO-Blue-USA as described on pages 9 and 15.

If you or a covered family member move outside the service area, or no longer work there, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances Beyond Plan Control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of Benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member are eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health Insurance and Automobile Insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed allowable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of any prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care doctor must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage

General Limitations *continued*

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' Compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Program (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, And Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other government Agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance And third party Actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name**.** If you need more information about subrogation, the Plan will provide you with its subrogation procedures. Call 530.666.2238.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition**. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services and supplies related to sex transformations;
- Procedures, services, drugs and supplies related to sexual dysfunction or sexual inadequacies (including penile prostheses) except as provided for medically documented treatment of organically based conditions;
- Services performed by a close relative (the spouse, child, brother, sister, or parent of a subscriber or dependent) or a person who ordinarily resides in the member's home; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $5 office visit copay for other than preventive and maternity services, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** a $25 copay for a doctor's house call, $5 for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups (**You pay** nothing)
- Mammograms are covered as follows: for women 35 through 39, one mammogram during these five years; for women 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness. (**You pay** nothing)
- Routine immunizations and boosters (**You pay** nothing)
- Hearing screening by the primary care doctor for members under the age of 18 to determine the need for an audiogram or hearing correction (You **pay** nothing)
- Vision screening by the primary care doctor for members under the age of 18 to determine the need for refraction or vision correction (**You pay** nothing)
- Consultations by specialists (**You pay** $5)
- Self-referral to a participating specialist through the Access+ HMO option (**You pay** $30 per visit)
- Diagnostic procedures, such as laboratory tests and X-rays (**You pay** nothing)
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If the hospital stay is less than 48 hours after a regular delivery or 96 hours after a cesarean section delivery, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating physician. The treating physician, in consultation with the mother, will determine whether this visit will occur at home, the contracted facility or the physician's office. Also included is the prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancy cases. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment. (**You pay** nothing)
- Voluntary sterilization and family planning services (**You pay** $100 for tubal ligation; $75 for vasectomy; nothing for office visits)
- Diagnosis and treatment of diseases of the eye (**You pay** $5)
- Allergy testing and treatment (**You pay** $5 per visit). **You pay** nothing for injectables/serum unless they are made separately (e.g., customized antigens), in which case **you pay** a coinsurance of 50% of allowable charges.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints (**You pay** $5)

Medical and Surgical Benefits *continued*

What is covered
Continued

- Cornea, kidney, heart, skin, lung, heart and lung in combination, kidney and pancreas in combination, liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions when authorized in writing by the Blue Shield Medical Director and performed at approved facilities: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Breast cancer, multiple myeloma and epithelial ovarian cancer are covered only when approved by the Plan's Medical Director and performed as part of a clinical trial conducted at a Cancer Research Facility that is funded by the National Cancer Institute. (**You pay** nothing) Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.

- Women who undergo mastectomies may, at their option, remain in the hospital up to 48 hours after the procedure**. (You pay** nothing)

- Outpatient hospital services for treatment or surgery and necessary supplies (**You pay** $50 per treatment or surgery)

- Chemotherapy, radiation therapy, dialysis and inhalation therapy (**You pay** $5 per office visit or **you pay** nothing in a hospital setting)

- Surgical treatment of morbid obesity (**You pay** nothing as an inpatient)

- Orthopedic devices (and their repair) such as braces; functional foot orthoses (**You pay** 50% of allowable charges)

- Prosthetic services (and their repair) such as artificial limbs and contact lenses necessary to treat certain medical eye conditions. Contact the plan for details. (**You pay** 50 % of allowable charges)

- Durable medical equipment, such as wheelchairs and hospital beds (**You pay** 50% of allowable charges)

- Home health service of nurses and health aides, including intravenous fluids and medications, when prescribed by Plan doctor, who will periodically review the program for continuing appropriateness and need (**You pay** $5 per visit)

- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers**. (You pay** nothing)

- Urgent care services through HMO-Blue-USA when traveling out-of-state by calling 1-800/4-HMO-USA for a referral. When traveling within State but out of your Service Area, call your primary care physician or 1-800/334-5847. (**You pay** a $50 per visit copay)

- Injectable medications (Other than allergy and infertility injections, y**ou p**ay nothing)

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Medically necessary non-surgical treatment (e.g., splint therapy and physical therapy) of Temporomandibular Joint Syndrome (TMJ) is covered. Surgical and arthroscopic treatment of TMJ is covered if prior history shows conservative medical treatment has failed. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. (**You pay** nothing as an inpatient)

Limited benefits
Continued

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. (**You pay** nothing as an inpatient)

Rehabilitative therapy will be covered for physical, speech, occupational and inhalation; **you pay** a $5 copay per outpatient session. This is a covered benefit when determined by the Plan to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of these services. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Chiropractic services are covered up to 20 visits per calendar year. **You pay** a $5 copay per visit. Each member is allowed a pre-authorized appliance benefit of up to $50 per year. Examples of covered appliances are elbow supports, back supports (thoracic) and cervical collars.

Diagnosis and treatment of infertility is covered. Benefits are provided for the following induced fertilization procedures: six natural artificial inseminations and three stimulated artificial inseminations and one GIFT (gamete intrafallopian transfer), one ZIFT (zygote intrafallopian transfer), or one in-vitro fertilization (IVF) per calendar year. **You pay** 50% of allowable charges; preapproval must be obtained from the Plan by the member's physician. Cost of donor sperm, eggs and frozen embryo is not covered. At the doctor's office or pharmacy, **you pay** 50% of allowable charges for injectable drugs. At Plan pharmacies, **you pay** a $6 copay for oral infertility drugs.

Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided at a Plan facility, if medically necessary with the appropriate treatment plan; **you pay** $5 per visit

What is not covered

- Physical examinations not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Homemaker services
- Hearing aids and examination for hearing aids
- Transplants not listed as covered
- Assisted reproductive technology (ART) procedures not listed as covered
- Organ donor costs and travel expenses
- Blood donor costs
- Routine foot care
- Wigs
- Speech or language assistance devices
- Services for or related to acupuncture
- Surgery to correct refractive error such as radial keratotomy and refractive atoplasty

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits up to 100 days each calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Admissions to a subacute care setting require prior Plan approval and are limited to 100 days each calendar year. **You pay** nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Care received in the home is limited to 100 visits per year and is subject to a $5 copay per visit. Care received in a hospice facility provides for 100 days of service, applied against the Extended Day Care Limits, without copayment. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental Procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient Detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 20 for nonmedical substance abuse benefits.

What is not Covered

- Personal comfort items, such as telephone and television
- Blood donor costs
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a Medical Emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury and disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that you and the Plan may determine are medical emergencies -- what they all have in common is the need for quick action.

Emergencies Within the Service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

Emergencies outside The service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per emergency room visit or per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

Emergency Benefits *continued*

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not Covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area (unless the circumstances as verified by the Plan were beyond the mother's control)

Filing claims For non-Plan Providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Mail this information to Blue Shield of California HMO Member Services, P.O. Box 272550, Chico, CA 95927. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 24-25.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

Up to 40 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay** a $25 copay for each covered visit 1-20 and 50% of allowable charges for visits 21-40 -- all charges thereafter.

Inpatient Care

Up to 30 days of hospitalization each calendar year, **you pay** $50 per day for first 30 days or $25 per day of day-care for up to 60 days, or a combination of inpatient and day-care where 2 day-care days count as 1 inpatient day up to a maximum of 30 equivalent inpatient days. **You pay** all charges thereafter.

Psychiatric day-care is care in which patients participate during the day, returning to their homes or other community placement during the evening or night.

What is not Covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Self-referrals to psychiatrists or other mental health care providers under the Access+ HMO option

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan providers for treatment are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions benefits visit limitation and copays apply to any covered substance abuse care.

What is not Covered

- Treatment that is not authorized by a Plan doctor.
- Self-referral to any mental health provider through the Access+ HMO option

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. Coverage is based on the use of the Prescription Drug Formulary, a copy of which is available to members. Non-formulary drugs will be covered when prescribed by a Plan doctor and approved by the Plan. Members' doctors are responsible for obtaining authorizations from the Plan for all non-formulary drugs. Members should not become directly involved with the Plan for this preauthorization process. Instead, their physicians should document medical necessity for non-formulary drugs during regular business hours by calling the Plan's toll-free pharmacy hotline, 1-800-535-9481.

In lieu of brand name drugs, generic drugs will be dispensed when substitution is permissible by the physician. If you request a brand name drug when a generic drug is available, **you pay** the difference between the cost of the brand name drug and its equivalent generic drug, plus the copayment. **You pay** a $6 copay per prescription at Plan pharmacies. To obtain prescription drugs, present your Blue Shield Access+ HMO identification card at a participating pharmacy. For out-of-state emergencies, **you pay** a $6 copay.

Mail Order Drug Program—Prescriptions are also available by mail for up to a 90-day supply. Generic drugs will be dispensed in lieu of name brand drugs when substitution is permissible by the physician. **You pay** a $6 copay per prescription unit or refill. If you request a brand name drug when a generic drug is available, **you pay** the difference between the cost of the brand name drug and its equivalent generic drug, plus the copayment**.** Submit prescriptions with the applicable copayment and your FEHB subscriber number to:

Merck-Medco Rx
P.O. Box 3435
Spokane, WA. 99220-3435

Covered medications include:

- Medically necessary drugs for which a prescription is required by law
- Oral contraceptive drugs—up to a three-cycle supply may be obtained for a single copay charge
- Insulin, with a copay for each 34 or 90-day supply
- Disposable needles and syringes needed for injecting covered medication
- Diabetic supplies limited to insulin syringes, needles and glucose testing tablets and strips
- Intravenous fluids and medications for home use and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits. Depo Provera is not a covered benefit unless prescribed for a medical condition; contraception is not such a condition.
- Drugs for sexual dysfunction or sexual inadequacies will be covered when the dysfunction is caused by medically documented organic disease. Prior Plan approval is required and the maximum dosage dispensed will be limited by the protocols established by the Plan. Certain drugs for these conditions are not available through the Mail Order option.

Prescription Drug Benefits *continued*

What is not Covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Contraceptive devices
- Implanted time-release medications, such as Norplant
- Appetite suppressants
- Smoking cessation drugs

Other Benefits

Dental care

Accidental injury Benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury commencing within 90 days of the accidental injury or within 90 days of medical appropriateness of treatment and within one year of the injury. **You pay** a $5 copay per visit.

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of disease of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Medical Eye Services (MES) providers; **you pay** a $5 copayment. MES directories can be ordered by calling 1-800/334-5847.

What is not Covered

- Corrective lenses or frames
- Eye exercises

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with FEHB, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Blue Shield Dental Option -- Comprehensive and Affordable

Enroll in Access+ HMO and pay dues directly to Blue Shield to join this dental plan. Dues can be paid monthly or quarterly (Dues are also shown on a biweekly basis for your convenience in comparing costs.). Call 1-888/271-4929 for a list of dentists, a summary of benefits and an enrollment form.

	Biweekly Dues	Monthly Dues	Quarterly Dues
Self only	$6.40	$13.86	$41.58
Two party	$12.78	$27.68	$83.04
Family	$18.91	$40.96	$122.88

Care must be received from or arranged by a Blue Shield Dental Option provider. Below are sample copayments:

Office visits	$5	Fillings (per surface)	$15	Root canal (one canal)	$125
Bitewing X-rays	$0	Metal crowns (each)	$250	Full upper or lower denture	$250
Prophylaxis	$0	Single, routine extraction	$20	Orthodontics (children only)	$1,800

Receive Discounts from Vision One Eyecare Program on Frames and Lenses

Federal employees with Access+ HMO coverage can enjoy savings of up to 66.7% on frames and lenses through our Vision One Eyecare Program at almost 250 Cole Vision California locations. Cole Vision services are available in the optical departments of many Sears, Montgomery Ward and JCPenney stores, at Pearle Vision locations and at offices of participating private practice doctors. There is no added premium for this money-saving benefit. Simply present your Access+ HMO identification card when you pay for your eyewear and the discounts are automatic.

For coverage of eye refractions see Page 22.

Significant Discounts through the mylifepath[sm] Program - Acupuncture, Massage & More

Blue Shield of California offers you participation in mylifepath, which entitles you to significant discounts on health and wellness services. When you see a practitioner in the mylifepath network, you'll experience substantial savings on acupuncture, chiropractic, massage, fitness centers, health spas, yoga classes, diet and nutritional counseling and wellness programs. You will be responsible for all charges remaining after the discounts. For more details on all services, please call 1-888-999-9452. Also visit our website, mylifepath.com, for health information and news about other value-added services.

Medical Care for Vacations, Business Travel and College Students

HMO-Blue-USA covers you and eligible family members in hundreds of cities in 43 states and the District of Columbia while you're on vacation, on business travel or away from home at college. There are no additional premiums for this Away from Home Care You pay office copayments, which vary from state to state ($5 to $25) for guest visits and $50 for urgent care visits. Call 1-800/334-5847 for details.

Blue Shield 65 Plus Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 5, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan if one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will have to pay for hospital coverage in certain instances in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800/495-7887 for information on the Medicare prepaid plan and the cost of that enrollment. Blue Shield 65 Plus is now available in Alameda, Contra Costa, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco, San Mateo and Santa Clara counties. Kern, Merced, San Diego, San Joaquin, Stanislaus and Ventura counties are added effective January 1, 1999.

Benefits on this page are not part of the FEHB Contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Office at 1-800/334-5847 or you may write to the Plan at Blue Shield of California HMO Member Services Department, P.O. Box 272550, Chico, CA 95927. You may also contact the Carrier by fax at 916/351-7790.

Disputed claims Review

Plan reconsideration

If a claim for payment of services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit). OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime telephone number.

OPM review
Continued

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement – If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Blue Shield of California Access+ HMO Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide Changes

Several changes have been made to comply with the President's mandate to implement the Patients' Bill of Rights.

- If you have a chronic, complex or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals. See page 10.
- A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. See page 18.
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under the Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 40 outpatient Mental Conditions visit limit.

Changes to This Plan

- The Plan will add coverage for functional foot orthoses, subject to a member coinsurance of 50% of allowable charges.
- The Plan will add coverage for a follow-up visit for the mother and child within 48 hours of discharge when the mother's stay is less than 48 hours after a regular delivery or 96 hours after a cesarean section delivery.
- The member copayment for outpatient hospital services for treatment or surgery will be changed to a $50 copayment per treatment or surgery. Previously, the copayment was zero.
- The allergy testing and treatment benefit has been changed to a $5 copay per visit. There is no additional charge for injectables/serum unless they are made separately (e.g., customized antigens), in which case the coinsurance is 50% of allowable charges.
- The Plan will now cover contact lenses necessary to treat certain medical eye conditions at a member coinsurance of 50% of the allowable charge. Contact the Plan for details.
- The Plan's coverage of drugs for sexual dysfunction or sexual inadequacies is shown under Prescription Drug Benefits on page 21.

Other Changes

- Blue Shield of California has acquired CareAmerica, another health benefits plan that participates in the FEHB Program. All members currently enrolled in CareAmerica (enrollment code BJ) will automatically be transferred to Blue Shield of California (enrollment code SJ) unless the member makes a positive election to change to another health benefits plan during Open Season.
- The Plan has revised its procedures for a member's change of a Plan doctor when the member is in a treatment course and when the personal care doctor leaves the Plan. See page 8 for details.

Summary of Benefits for Blue Shield of California Access+ HMO - 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan pays/provides Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing 17
	Extended care	All necessary services, limited to 100 days each calendar year. **You pay** nothing 17
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care or 60 days of day care (or a combination as described) per year. You pay $50 per inpatient day and $25 per day-care day 20
	Substance Abuse	Covered under Mental conditions 20
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care. **You pay** a $5 copay per office visit; **$30 per self-referred Access+ specialist office visit;** $25 per house call by doctor. Preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** nothing 14
	Home health Care	All necessary visits by nurses, therapists and health aides. You pay $5 per visit 14
	Mental Conditions	Up to 40 outpatient visits per year. **You pay** a $25 copay per visit for visits 1-20; 50% of charges for visits 21-40 20
	Substance Abuse	Covered under Mental Conditions 20
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan 18
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy or through the Plan's mail order program. You pay a $6 copay per prescription unit or refill 21
Dental care		Accidental injury benefit; **you pay** $5 per office visit 22
Vision care		One eye refraction annually. **You pay** a $5 copay 22
Out-of-pocket maximum		Copayments and percentages of allowable charges are required for a few benefits, however, after your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $2,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs, outpatient mental health and substance abuse, infertility services, or the $30 copay for self-referral specialty visits 10

1999 Rate Information for Blue Shield of California Access+ HMO

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service Employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**
Self Only	**SJI**	**$ 55.28**	**$18.42**	**$119.76**	**$39.92**	**$65.41**	**$8.29**
Self and Family	**SJ2**	**$137.14**	**$45.71**	**$297.14**	**$99.04**	**$162.28**	**$20.57**